Statewide Universal Health Care Access Plans

for

Single Payer System

&

Regulated Multiple Payer System

Montana Health Care Authority

July 1994

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Montana Health Care Authority
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MONTANA HEALTH CARE AUTHORITY

July 1994

Dear Fellow Montanans:

In the spring of 1993, the Legislature passed and the Governor signed into law Senate Bill 285, which mandates health care reform and establishes the Montana Health Care Authority as the agency responsible for managing this reform process.

There are several problems which led to the passage of this legislation: first, cost increases in the health care system in Montana during the past 15 year have outstripped corresponding increases in total wages and salaries by a margin of 3 to 1, which means that the average Montanan is forced to pay an increasing proportion of his or her income for health care services.

Second, some 100,000 Montanans are without any health insurance coverage, while still others are burdened with inadequate coverage. In addition, anyone can lose health insurance coverage at any point in time as a result of either losing their job, changing jobs, or becoming seriously ill.

Third, the state's share of Medicaid costs (the program which provides health care coverage for the poor, disabled and elderly) is now over 15 percent of Montana's General Fund budget, having doubled in the past five years. This means that the Legislature has been forced to divert resources which have in the past funded education, public safety and infrastructure improvements.

These and other factors prompted the Legislature and Governor to decide the time had come for the state to encourage health care reform in Montana. The Health Care Authority was charged with directing this process, principally through the development of two alternative approaches: a single payer system and a regulated multi-payer system. These "universal access plans" are intended to guarantee universal health care coverage for all Montanans, contain cost increases in health care expenditures, improve access to health care services in those areas where they are now deficient, and maintain the current high quality of health care services. The Authority's final report to the Legislature on these plans is due by October 1, 1994.

This discussion draft is intended to generate widespread review and comment from you, the people of Montana. It will serve as the basis for a series of town meetings, regional health care planning board meetings, and public hearings during the months of July, August, and September for the purpose of collecting citizen feedback.

We sincerely hope you will take advantage of this opportunity and help the Health Care Authority design the best possible health care system for Montana. We look forward to hearing from you during the next three months.

Sincerely,

Dorothy

Dorothy Bradley
Chair

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INTRODUCTION

Rapidly rising health care costs, a growing number of persons without health insurance, and concern among those with coverage that their insurance may not be there for them when they need it most have led the majority of the public to believe that changes must be made to the existing health care system. The big question is what those changes should be. While Congress is considering a variety of national health care reform proposals, many states across the country have undertaken a careful examination of their own options. A number of these states, not content to wait for the federal government to act, have actually enacted and are in the process of implementing their own state-level health care reform strategies.

Montana is one of the states that has moved to address the need to improve the current health care system. In 1993, a bipartisan effort in the Legislature enacted Senate Bill 285, which established the Montana Health Care Authority. The statute charged the Authority with developing a comprehensive statewide health care reform strategy that would provide all Montanans with improved access to high quality, affordable health care. As part of its strategy development process, S.B. 285 requires the Authority to develop two alternative universal access plans: a tax-financed single payer system and a regulated multi-payer system. By October 1, 1994 the Authority will report back to the Legislature concerning the specific design of these models. The Legislature will then decide which of the two plans is most appropriate for Montana.

One important element of the Authority's workplan for designing these alternative universal access plans is its effort to solicit input from Montana communities and residents. The Authority is doing so through a variety of mechanisms, including:

- holding the Authority's monthly meetings in different communities throughout the state; and
- convening a series of electronic citizens' forums to solicit the public's views on health care reform.

The publication of this interim report is another effort to solicit input from Montana's residents on health care reform matters. The Authority will seek additional public feedback on this document through a series of town meetings, regional health planning board meetings, and public hearings that have been scheduled in July, August, and September.

Much work remains to be done in shaping the Authority's recommendations concerning the alternative universal access plans that will be submitted to the Legislature in the fall. However, this report provides Montanans with preliminary findings on this matter. This report will heighten the public's awareness of the problems within the current health care system that must be addressed, and provide Montanans with a better understanding of the strategies that S.B. 285 requires the Authority to consider.

The Authority welcomes and encourages feedback on the ideas contained in this document and will take them into consideration as it prepares its final report to the Legislature.

WHY HEALTH CARE REFORM?

There are several important reasons that health care reform is needed in Montana.

They include the following:

■ ***Rapidly rising health care spending that has outstripped the growth in Montana's economy and has placed a growing burden on Montana families and state government.***

While average per capita health care spending in Montana is less than the national average, it has grown considerably in past years. One study estimated that from 1980 to 1990, total health care spending in Montana rose from roughly $676 million to over $1.6 billion in 1990, an overall increase of 143 percent. This translates into an increase in per capita spending from $859 to $2,059 during that period.

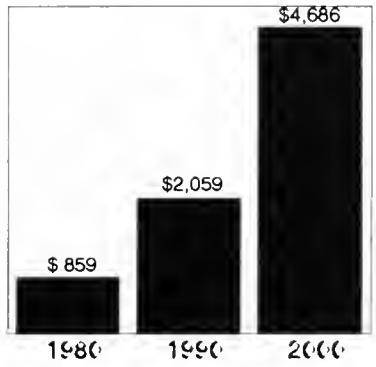
If current trends in health care cost escalation were to continue, the study projects that by the year 2,000 health care spending in Montana would reach nearly $3.5 billion, or roughly $4,700 per person (see Figure 1).

These increases in health care spending have far outstripped the ability of Montana families to pay for them. For example, from 1980 to 1990, when health care spending was estimated to have grown by 143 percent, total wages and salaries for Montana workers increased by only 52 percent (see Figure 2).

As a result, in 1980, the average Montana family spent $1,345 on health-related expenditures, or 7.5 percent of their income. By 1991, the average health-related payment made by a Montana family had increased to $3,154, or 10.8 percent of their annual income.

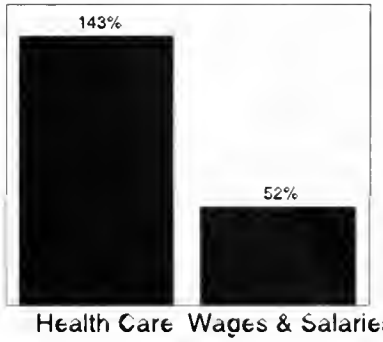
The burden of rising health care costs has been felt not only by Montana families and businesses, but by state government as well.

Figure 1.
ESTIMATED PER CAPITA HEALTH CARE SPENDING IN MONTANA: 1980, 1990 & 2000



SOURCE: Families, U.S.A.

Figure 2.
GROWTH IN ESTIMATED TOTAL HEALTH CARE EXPENDITURES VS. GROWTH IN TOTAL WAGES AND SALARIES IN MONTANA: 1980 TO 1990



SOURCE: Families, U.S.A. and Montana Department of Labor

The state's share of the costs of the Medicaid program is approaching 15.6 percent of the annual general fund budget, thereby severely reducing Montana's ability to finance other badly needed services such as education, infrastructure development and public safety. The state employee health benefit coverage further adds to the portion of the state's

general fund budget that is consumed by health care expenses.

■ ***An estimated 100,000 or more Montanans lack any form of health care coverage.***

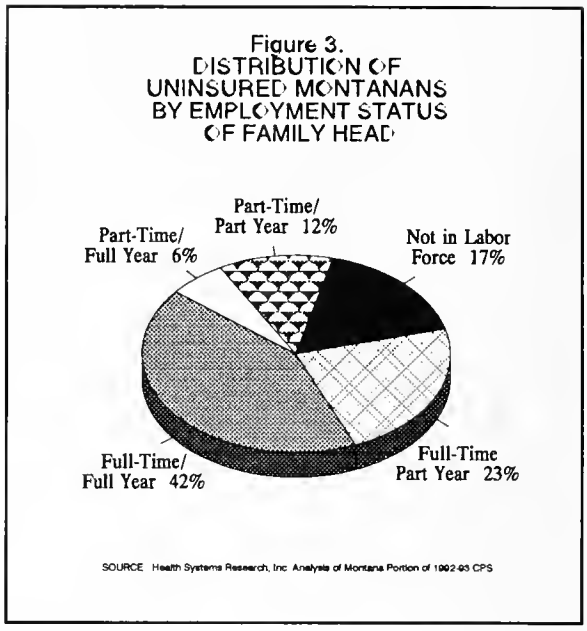
Despite (or perhaps because of) the significant and ever-growing amount of money spent on health care, a significant portion of Montana's population lacks even basic health insurance protection. Data from several different sources indicate that from 12 to 16 percent of the state's population are uninsured at a given point in time.

These uninsured individuals are those who are not covered by any form of private insurance or by any public programs, such as Medicare or Medicaid. They often do not make use of cost-effective preventive health care or may delay seeking treatment for a health problem until their condition has worsened and becomes much more costly to treat. When they do seek care, it is frequently in very expensive settings, such as hospital emergency rooms.

A closer look at the characteristics of the uninsured Montanans reveals that:

■ ***The vast majority of uninsured Montanans have direct or indirect ties to the work force.***

Nearly 85 percent of Montana's non-elderly uninsured are either adults who work on a full or part-time basis at some point during the year or dependents of these workers (see Figure 3). Well over half of all uninsured workers are employed by small businesses with less than 25 employees.



■ ***Despite this link to the work force, the majority of the uninsured are low income individuals and families.***

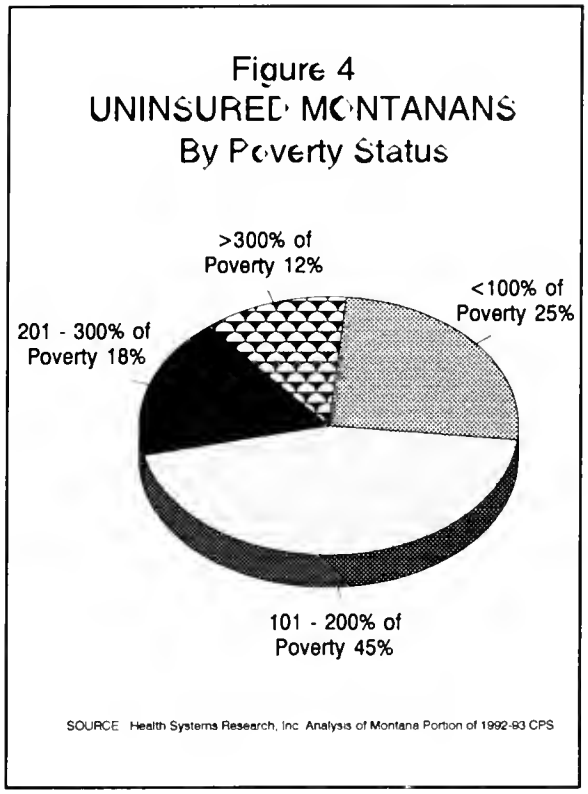
While a quarter of the state's uninsured have incomes below the poverty line (e.g., $12,320/year for a family of three in 1994), nearly one half are low income individuals and families with incomes between one and two times the poverty level. This latter group is often referred to as the "working poor" (see Figure 4).

■ ***Many of the state's uninsured are children and young adults.***

One quarter of the state's uninsured population are children under the age of 18, while young adults aged 18 to 24 are the group at highest risk of being uninsured.

■ ***A significant number of Montanans are "underinsured."***

In addition to these uninsured individuals, an equal or even greater number of Montanans are likely to have coverage that does not provide them with adequate protection



against a catastrophic illness or with financial access to primary and preventive services. These persons are considered to be "underinsured."

■ ***Because of the significant provider shortages that exist throughout the state, many Montanans do not have reasonable access to health care services.***

Sadly, one of the reasons that Montana's per capita health care spending is below the national average is the fact that the state's health care delivery system is a very fragile one that leaves much of the state's highly rural population without reasonable access to needed primary care and related health care services.

The problems with the state's health care delivery system are reflected in the fact that half of Montana's counties are officially designated as Medically Underserved Areas (MUAs), a federally developed measure identifying areas that are critically underserved. Forty-one of the state's 56 counties are designated as Health Professional Shortage Areas (HPSAs), which is another federally established designation given to areas suffering from serious health personnel shortages.

Further evidence of the strain that exists within Montana's health care delivery system is demonstrated by the precarious financial status of the state's hospitals. Data from the Montana Hospital Association indicate that hospitals with less than 30 beds -- about half of all hospitals in the state -- have suffered significant financial losses for at least eight consecutive years. Factors which contribute to this bleak financial picture are the burden of providing uncompensated care to the uninsured, and the low reimbursement rates from public programs such as Medicare that do not fully cover the cost of providing care to persons insured by these programs.

GUIDING PRINCIPLES FOR HEALTH CARE REFORM

The Montana Health Care Authority believes that the goal of the State of Montana's health-related policies should be to improve the health status of its population. To achieve this goal, the state should develop and implement a multi-faceted strategy that includes health care system reform, efforts to improve the population's health-related behavior, and other public-health oriented activities.

In pursuit of this goal, S.B. 285 specifies that the policy of the State of Montana should be to ensure that all residents have access to quality health care services at costs that are affordable.

The following are specific objectives of a reformed health care system identified in S.B. 285:

- Maintain and improve the quality of health care services offered to Montanans;
- Contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income;
- Avoid unnecessary duplication in the development of health care facilities and services;
- Encourage regional and local participation in decisions about health care delivery, financing, and provider supply;
- Promote the rational allocation of health resources in the state;
- Facilitate universal access to preventive, primary, and other medically necessary health care; and
- Educate consumers about the proper use of the health care system, and about the importance of individuals assuming greater responsibility for their own health status by improving their health-related behavior.

The Authority also suggests that the reformed system meet the following additional objectives:

- Operate as efficiently and effectively as possible, with the administrative aspects of the system made as simple and "user friendly" as possible; and
- Provide accurate and accessible information that will enable consumers and providers to make more informed decisions and that will provide better measures of the performance of the health care delivery system, including patient outcomes.

Finally, in reforming the health care system to achieve these objectives, the Authority believes that the state must ensure that any negative impacts of its reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

UNIVERSAL ACCESS PLANS: ALTERNATIVE MODELS

As noted earlier, S.B. 285 requires that the Montana Health Care Authority develop and submit to the legislature by October 1, 1994 recommendations for two universal access plans: a single payer system and a regulated multiple payer system. The statute defines these models as follows:

- *"A **single payer system** is a method of financing health care services predominantly through public funds so that each resident of Montana receives a uniform set of benefits as established through statute or administrative rule. Policies governing all aspects of the management of the single payer system would reside with the state government, and benefits must be administered by a single entity."*
- *"A **regulated multiple payer system** is a method of financing health care services through a mix of public and private funds so that each resident of Montana receives a uniform set of benefits as established by statute or administrative rule. State government has responsibility for regulating*

the multiple entities that provide benefits to residents, including regulations for enrollment, change in premium rates, payment rates to providers, and aggregate health expenditures."

S.B. 285 also identifies a set of specific features that both the single payer and regulated multiple payer plans must include in the areas of health care access, cost containment, and service delivery. These are summarized in Table 1.

The Authority's preliminary recommendations concerning the design of plans that meet these objectives are presented below.

THE PROPOSED SINGLE PAYER ALTERNATIVE

Consistent with the definition of the single payer model contained in S.B. 285, preliminary recommendations would replace the current system of premium-financed private insurance and tax-supported public program coverage with a single system financed primarily by tax revenues that ultimately would provide coverage of a comprehensive set of benefits to all Montanans.

However, unlike the Canadian single payer system, the proposal combines the positive equity and efficiency aspects of such a single payer system with additional efficiencies which may be derived from market-based competition among health plans.

Structure and administration. Under the proposed single payer system, tax revenues to support universal coverage will flow into state government. While a single government entity will assume overall responsibility for policy development and oversight of the system, this entity would contract out with private organization(s) for the bulk of the administrative tasks required to operate a single payer system (e.g., enrollment, claims processing, data analysis, etc.).

This entity or its contractor would provide eligible individuals with a choice of obtaining coverage from either fee-for-service (FFS) or managed care plans, each of which would offer the uniform benefit package described below. This aspect distinguishes the proposed single payer system from the Canadian model, in which all services are provided on a fee-for-service basis. While providing covered individuals and families with a choice of health care plans would reduce the administrative cost savings that would otherwise be achieved through Canadian-like approach, any loss in administrative savings might well be offset by the benefits to consumers of having a choice of plans, as well as savings that might accrue from price competition among plans.

Populations to be covered under the single payer plan. Under a true single payer system, all persons should be covered through such a system. However, while the ultimate goal of the plan would be to include all Montanans within the single payer system, significant federal restrictions currently limit the state's ability to bring everyone under the program.

For example, the federal Employee Retirement and Income Security Act of 1974, known as ERISA, prohibits states from regulating the health benefits provided by larger businesses or labor unions that "self-insure" or "self-fund" (i.e., that fund their own health care benefits) rather than paying premiums to insurance companies. Unless the ERISA statute is changed or Montana receives special Congressional approval,

Table 1.
Statutory Requirements for the Universal Access Plans

According to S.B. 285, both the single payor and the regulated multi-payor plans to be developed by the Montana Health Care Authority must provide:

- Guaranteed access to health care services for all residents of Montana;
- A uniform system of health care benefits;
- A unified health care budget;
- Portability of coverage, regardless of job status;
- A broad-based, public or private financing mechanism to fund health care services;
- Consideration of the limitations of public funding;
- A system capped for provider expenditures;
- Global budgeting for all health care spending;
- Controlled capital expenditures;
- A binding cap on overall expenditures;
- Policymaking for the system as a whole and accountability within state government;
- Incentives to be used to contain costs and direct resources;
- Administrative efficiencies;
- A health care resource management plan that provides for the distribution of health care resources within regions of the state;
- The appropriate use of mid-level practitioners, such as physician's assistants and nurse practitioners;
- Mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;
- Integration, to the extent possible under federal and state law, of benefits provided under the health care system with benefits provided by the Indian Health Service and the United States Department of Veteran Affairs and benefits provided by the Medicare and Medicaid programs;
- An actuarially sound estimate of the costs of implementing the plans through the year 2005;
- Stable financing methods, including consumer cost sharing;
- Procedures for evaluating the quality of health services; and
- Education of the public concerning the plan.

ERISA would likely prohibit the state from extending the single payer plan to employees covered by self-funded plans. In addition, special federal waivers or legislation would be needed to include persons currently covered by the Medicare, Medicaid, military health care, or CHAMPUS programs in the single payer plan.

Montana therefore must seek the necessary federal waivers and/or legislation to include these populations within the proposed single payer plan. It is important that these waivers allow the state to redirect any federal health care expenditures that would otherwise have been made on behalf of these individuals into the funding for the single payer system. The state should also seek federal approval to incorporate funds used to provide services to Montana veterans through the Veterans' Administration program into the single payer system and to provide these veterans with coverage through the system.

Finally, the state should enter into negotiations with the sovereign Indian tribes and the appropriate agencies of the U.S. government about the possibility of integrating Indian Health Service (IHS) funds into the single payer financing mechanism and providing coverage to tribal members through the single payer system.

Uniform benefit package. The Authority recommends that the uniform benefit package provided to all individuals under the single payer system be a relatively comprehensive one that includes coverage of a full range of preventive, primary, and acute care services, including physician services, hospital care, prescription drugs, comprehensive dental services for children and emergency dental services for adults.

A fuller description of the services that would be included under the single payer benefit package is presented in Table 2. Consistent with the decision to allow both fee-for-service and capitated managed care plans to be offered under the single payer system, two slightly different benefit packages are described in this table: a "high cost sharing" package to be provided under fee-for-service plans, and a "low cost sharing" package similar to that provided through capitated health maintenance organization (HMO) plans.

Issues associated with providing additional services to low income or other vulnerable populations (e.g., persons in need of long-term care services) will be addressed as part of the Authority's (and the Montana Department of Social and Rehabilitative Services') subsequent examination of long-term care reform.

Preliminary cost estimates. As shown in the chart below, preliminary estimates prepared by the Authority's actuarial consultants indicate that the monthly per capita costs of the benefits covered by the single payer plan, at 1994 cost levels, would range from approximately $134 to $142 per adult and from $67 to $72 per child, depending upon whether they enroll in a high or low cost-sharing plan.

Estimated Per Capita Cost of Coverage Under the Proposed Single Payer System (at 1994 Price Levels)

	High Cost Sharing Plan	Low Cost Sharing Plan
Adult	$134.06	$141.90
Child	$ 67.03	$ 70.95

If all Montanans, except persons eligible for Medicare or Indian Health Service benefits, were covered under the single payer plan, the actuaries project that the total cost of

Table 2.
COMPREHENSIVE BENEFIT PACKAGE PROVIDED UNDER SINGLE PAYER SYSTEM

SERVICE TYPE	HIGH COST SHARING (FFS PACKAGE)	LOW COST SHARING (HMO PACKAGE)
DEDUCTIBLES	$200/individual; $400/family. Separate deductible for prescriptions and dental.	None
COINSURANCE	20%, unless otherwise noted	None for "In-Network" Use. Min. 20% coinsurance for "Out of Network" use.
OUT-OF-POCKET MAX.	$1500/individual; $3000/family	$1500/individual; $3000/family
MAXIMUM DOLLAR COVERAGE LIMITS	No maximum lifetime limits	No maximum lifetime limits
HOSPITAL		
Inpatient Care	Covered	Covered
Outpatient Care	Covered	$10 copay per visit
MEDICAL		
In-Hospital	Covered	Covered
Surgery - Inpatient	Covered	Covered
Surgery - Outpatient	Covered	Covered
Primary and Preventive - routine visit - well baby - immunization - pap smear	Preventive benefit package recommended by the U.S. Preventive Services Task Force: full coverage Primary care: 20% coinsurance	Preventive: benefit package recommended by the U.S. Preventive Services Task Force: full coverage Primary care: $10 copay
Specialty Care/Referral OB/GYN & Maternity - specialty - periodic OB/GYN exams - pre/post natal - delivery - newborn - Birthing Center	Covered Covered Prenatal care and clinician visits: full coverage.	$10 copay $10 copay per visit Prenatal care and clinician visits: full coverage.
OTHER		
Emergency Room	Covered	$25 per visit unless condition is an emergency.
Ambulance	Covered	Covered
Chiropractic	Covered	Covered
Physical/occupational therapy	Outpatient: covered; reassessed at 60 days for continued improvement.	Outpatient: $10 copay/visit; reassessed at 60 days for continued improvement.
Durable Medical Equipment	Covered	Covered
Hospice	Covered as inpatient alternative.	Covered as inpatient alternative.

Table 2.
COMPREHENSIVE BENEFIT PACKAGE PROVIDED UNDER SINGLE PAYER SYSTEM

SERVICE TYPE	HIGH COST SHARING (FFS PACKAGE)	LOW COST SHARING (HMO PACKAGE)
Home Care	Covered as inpatient alternative; mandatory reevaluation after each 60 day period.	Covered as inpatient alternative; mandatory reevaluation after each 60 day period.
Skilled Nursing Facility (SNF)	Covered as inpatient alternative; 100 day max. per year.	Covered as inpatient alternative; 100 day max. per year.
Vision and Hearing	Routine eye exam: covered. Glasses: limited to children, 1 set per year.	$10 per vision exam. Glasses: limited to children, 1 set per year.
Mental Health - Inpatient - Outpatient	*Inpatient*: 50% coinsurance plus one day deductible per admission, 30 days/yr; additional 30 days per year may be approved. *Intensive nonresidential*: Covered. Can substitute 2 days for 1 inpatient day (max. 60 days/yr); additional 60 days per year may be approved (50% coinsurance) *Outpatient*: Covered. For psychotherapy, 50% coinsurance, 30 visits per year; additional visits available at 4/1 ratio: per every four visits, one inpatient day lost.	*Inpatient*: $25 copay per visit, 30 days per year; additional 30 days per year may be approved. *Intensive nonresidential*: Full coverage for first 60 days. Substitute 2 days for 1 inpatient day (max. 60 days/yr); additional 60 days per year may be approved (25% coinsurance). *Outpatient*: $10 copay per visit. For psychotherapy, $25 copay per visit, 30 visits per year; additional visits available at 4/1 ratio: per every four visits, one inpatient day lost.
Alcohol/Drug Abuse - Inpatient - Outpatient	*Inpatient*: 50% coinsurance plus one day deductible per admission, 30 days/yr; additional 30 days per year may be approved. *Intensive nonresidential*: 50% coinsurance; substitute 2 days for 1 inpatient day (max. 60 days/yr); additional 60 days per year may be approved (50% coinsurance). *Outpatient*: Covered, 30 visits/year. Additional visits available at 4/1 ratio: per every four visits, one inpatient day lost. 30 days of group therapy available if individual received inpatient or intensive nonresidential treatment within the previous 12 months.	*Inpatient*: $25 copay per visit, 30 days/yr; additional 30 days per year may be approved. *Intensive nonresidential*: $25 copay; substitute 2 days for 1 inpatient day (max. 60 days/yr); additional 60 days per year may be approved (25% coninsurance). *Outpatient*: $10 copay, 30 visits/year. Additional visits available at 4/1 ratio: per every four visits, one inpatient day lost. 30 days of group therapy available if individual received inpatient or intensive nonresidential treatment within the previous 12 months.
Prescription Drugs	Individual outpatient deductible of $250/year; 20% coinsurance.	$5 per prescription.
Dental	$50 annual individual deductible. Adults, emergency only. Children, comprehensive coverage.	$10/visit: Adults, emergency only. Children, comprehensive coverage.

the plan in the year 1997 would be approximately $1.45 billion.

Clearly the financing of such a large tax-supported program would require a significant increase in state tax revenues (possible sources of these additional revenues will be discussed later in this report). However, several important points must be made to put this cost figure in proper context. First, while the establishment of such a program will result in a significant increase in tax-based health expenditures, these increases will be offset by eliminating the need for Montana businesses and individuals to purchase similar health care coverage on their own.

Second, the comprehensive nature of the benefit package provided under the single payer system will increase health insurance spending in the state above current levels. However, given the lower administrative costs associated with a single payer system, the cost of providing such uniform comprehensive coverage to all Montanans through the single payer plan would be less than if it was provided through the current system.

Finally, the establishment of the global budget/expenditure limits (discussed later) that S.B. 285 identifies as an integral part of both the single and multi-payer universal access plans is projected to result in future savings in the cost of providing this coverage. For example, the Authority's actuarial consultants estimated that the costs of the single payer plan in the year 2005 would be approximately $2.4 billion dollars with the expenditure limits established, versus $3 billion without them.

THE PROPOSED REGULATED MULTIPLE PAYER ALTERNATIVE

To achieve universal coverage through a multi-payer system, the Authority concluded that some form of coverage requirement or mandate was necessary. Otherwise, a small portion of the population might be willing to run the risk of becoming sick and incurring health care expenses that they could not pay and that would be passed on in the form of higher charges to persons who did have coverage.

The Authority therefore debated whether a coverage requirement should be imposed on all Montana businesses (an "employer mandate") or whether responsibility for obtaining health care coverage should rest with the individual. The majority of Montanans obtain their health care coverage through their place of employment. However, the Authority did not propose that all Montana employers be required to pay even a portion of the health care coverage costs for their workers and dependents because of the potential negative impact such a requirement might have on small businesses and, in turn, on the labor market within the state.

Instead, the proposed multiple payer plan would achieve universal coverage by requiring that all Montanans assume individual responsibility for obtaining health care coverage. At the same time, to encourage the continued availability of health care coverage through the workplace, under the proposed plan employers would be required to "offer" health care coverage to their workers. That is, while employers would not be required to pay for health care coverage for their workers, they would have to make arrangements to have health insurance premium contributions deducted from employees' payroll checks and

forwarded to insurance carriers, if requested by their employees.

Moreover, it is the Authority's hope that the establishment of an individual coverage requirement will not reduce availability of employer-financed coverage. Maintaining employer-funded coverage is particularly important because, under current federal and state tax policies, employment-based health care coverage is a tax-free benefit, while there is limited or no tax deductibility for the cost of purchasing non-employment-based coverage. To address this inequity, the Authority recommends that the state and federal tax codes be amended to provide favorable tax treatment to both individually-purchased or employment-based health care coverage costs.

In addition, the Authority is currently conducting a study of the feasibility of establishing one or more health care purchasing pools through which individuals and/or businesses could obtain health care coverage.

Uniform benefit package. The proposed multiple payer plan seeks to minimize any adverse effects of its individual coverage requirement by defining the minimum benefit package at a relatively low level and by calling for the establishment of public subsidies to assist low income persons in paying for such coverage.

The proposed minimum benefit package is modeled after an actual insurance product currently being sold with increasing frequency in Montana. A summary of this proposed minimum benefit package is presented in Table 3. The relatively low premium cost of this benefit package is the result of its relatively high cost-sharing requirements: annual deductibles of $1,000/person or $2,000/ family that applies primarily to hospital care, and a 50 percent co-insurance requirement on many services. No cost-sharing requirements would be applied, however, to certain preventive services. Annual out-of-pocket expenditures for most services are capped at $3,000/person and $6,000/family.

The Authority's actuarial consultants estimate the monthly premium cost of this benefit package to be the following:

- Single adult. $100
- Single adult and child(ren) . . $188
- Married couple $200
- Family. $306

It should again be emphasized that it is the Authority's intention to establish a minimum requirement that would result in all Montanans having a minimal level of coverage without requiring them to change their current coverage or to disrupt current employment-based health care coverage arrangements. Indeed, it is anticipated that the current heath insurance coverage held by most Montanans would easily meet this minimum standard.

Insurance reforms. Under the proposed multiple payer plan, health care coverage would be available on a guaranteed basis. That means that no one would be denied coverage or be dropped by an insurer because they are in poor health. The coverage would be portable as well, with persons not having to worry about losing their insurance if they change jobs. Finally, only a single twelve month exclusion of pre-existing conditions would be allowed. Once that exclusion period passed, no one would be subject to another waiting period, even if they change jobs, unless they fail to maintain continuous coverage.

The Authority also believes that ultimately health care premiums should be set on a modified community-rated basis: that is,

Table 3.
MINIMUM BENEFIT PACKAGE REQUIRED UNDER MULTIPLE PAYER SYSTEM

SERVICE	BENEFIT
DEDUCTIBLES	$1,000 per year/$2,000 per family; not applicable to participating professional providers.
COINSURANCE	50% unless otherwise noted.
OUT-OF-POCKET MAX.	$3,000 per person/$6,000 per family. Costs for certain services do not apply to out-of-pocket max., see below.
MAXIMUM LIFETIME BENEFIT	None
HOSPITAL	
Inpatient Care	Covered
Outpatient Care	Covered
MEDICAL	
In-hospital	Covered (no deductible)
Surgery - Inpatient	Covered (no deductible)
Surgery - Outpatient	Covered (no deductible)
Primary and Preventive - routine visit - well baby - immunization - pap smear	Preventive benefit package recommended by the U.S. Prevention Task Force: Covered in full (no deductible or coinsurance) Primary care services: Covered (no deductible)
Specialty Care/Referral	Covered (no deductible)
OB/GYN & Maternity - specialty - periodic OB/GYN exams - pre/post natal - delivery - newborn - birthing center	Professional Services: Covered (no deductible) Facility: Covered
OTHER	
Emergency Room Care	Facility: Covered Professional Services: Covered (no deductible) Non-emergent care not covered, subject to retrospective review
Ambulance	Covered; including ground and air, subject to review for medical necessity.
Prescription Drugs	After deductible is met, brand name prescriptions covered subject to standard coinsurance, generic prescriptions covered in full.
Dental	Not covered
Vision and Hearing	Screening as part of the preventive services package.

Table 3.
MINIMUM BENEFIT PACKAGE REQUIRED UNDER MULTIPLE PAYER SYSTEM

SERVICE	BENEFIT
Chiropractic	Covered up to $25 per visit, up to 35 visits per year.
Physical/Occupational Therapy	Inpatient: Covered Outpatient: Covered up to $2,000 per year. Combined inpatient/ outpatient limited to $20,000 per year, $100,000 lifetime max. Does not apply to maximum out-of-pocket payment.
Durable Medical Equipment	Covered for rental; replacements and repairs require preauthorization if over $200. Does not apply to maximum out-of-pocket payment.
Hospice	Covered as an inpatient alternative.
Home Care	Covered as an inpatient alternative.
Skilled Nursing Facility (SNF)	Covered as an inpatient alternative.
Mental Health - Inpatient - Outpatient	Inpatient: Covered up to 30 days per year for both mental health and substance abuse. Deductible applies only to facility charges, not professional services. Outpatient: Covered up to $1,000 per year for both mental health and substance abuse services. Does not apply to maximum out-of-pocket payment. No trade-offs between inpatient and outpatient benefits.
Alcohol/Drug Abuse - Inpatient - Outpatient	Inpatient: covered up to 30 days per year for both mental health and substance abuse services. Substance abuse benefits limited to $4,000 in any 24-month period, $8,000 lifetime maximum. Deductible only applies to facility charges, not professional services. Outpatient: Covered up to $1,000 per year for both mental health and substance abuse services. Does not apply to maximum out-of-pocket payment. No trade-offs between inpatient and outpatient benefits.

the cost of coverage would be the same for everyone, regardless of their sex, occupation, or health status. However, different premiums could be established for persons in different age groups. As a transition to this modified community rating approach, the Authority believes that the limitations on premium rate variations established as part of the state's small group market reforms should gradually be tightened and also extended to both the individual and larger group insurance markets.

To whom would the individual coverage requirement apply? The proposed individual health care coverage requirement would in general apply to all Montanans. However, as noted earlier, it is expected that the current private insurance coverage held by most Montanans will meet, and indeed exceed, the minimum health care coverage requirements. In addition, most persons who have public health care coverage will be considered or "deemed" to have coverage that meets the minimum requirements. For example:

- Persons covered by Medicare Part A and B will be deemed to have met the individual coverage requirement. Persons now covered by only Part A will be grandfathered in and

will be grandfathered in and considered to have met the individual coverage requirements. Future Medicare beneficiaries will have to be covered by both Medicare Part A and Part B in order to be considered to have met the requirement. (Note: Medicaid pays for the Part B premium for many low income Medicare enrollees.)

- Persons with military or CHAMPUS coverage will also be deemed to have met the coverage requirement.

- IHS coverage will also be considered as meeting the individual coverage requirement, although the Authority encourages the state to undertake discussions with the sovereign Indian tribes and the appropriate federal agencies about the possibility of utilizing IHS funds to obtain subsidized private sector coverage for their members if that is considered desirable.

- Veterans receiving services through the VA system would have the option of electing to have those services deemed as meeting the individual coverage requirements.

The state Medicaid program would continue to operate as it currently does, with this coverage considered sufficient to meet the individual coverage requirement. Indeed, the Authority recommends that efforts be made to maximize the use of federal Medicaid matching funds to finance coverage for Medicaid-eligible low income individuals. Because of the significant federal contribution to the cost of Medicaid coverage, efforts should be made to enroll as many Medicaid eligible individuals as possible in lieu of providing them with subsidies financed only with state funds. A requirement in S.B. 285 calling for uniform reimbursement rates across all payers would increase the cost of Medicaid coverage above current levels, but would also increase the flow of federal Medicaid dollars into the state and reduce any cost shifting to private payers that Medicaid might have previously generated.

Subsidies for low income individuals. Although the Authority has sought to make the premium costs of its minimum benefit package relatively inexpensive, nonetheless there are many persons within the state for whom purchasing such coverage on their own would pose a significant financial burden. To address this problem, the Authority recommends providing premium subsidies and assistance in meeting out-of-pocket expenses to certain low income individuals and families. For persons with incomes below the federal poverty line (e.g., an annual income of $12,320 for a family of three in 1994), the state would provide a full subsidy of the premium costs for the minimum coverage. Persons between 100 percent and 200 percent of poverty (e.g., a family of three with an annual income between $12,230 and $24,640) would receive a subsidy established on a sliding scale income-related basis.

Preliminary estimates of public subsidy costs. Based upon the premium cost estimates presented earlier and the proposed approach to providing subsidies discussed above, the annual cost (at 1994 cost levels) to the state of providing the premium subsidies is estimated to be roughly $80 million, although this cost could vary depending upon the extent to which currently insured low-income persons apply for these subsidies.

A discussion of possible sources of the additional state tax revenues needed to fund

these subsidies is presented later in this report.

Monitoring and enforcement. Several options are available. The state income tax system could be used to monitor and enforce compliance with the individual coverage requirement. Another possibility would be to require that children enrolling in schools present their certificate of health care insurance. The establishment of a 12-month pre-existing condition exclusion for non-continuous coverage would also provide an incentive for individuals to maintain health care coverage.

Necessary federal waivers. In order to implement a number of provisions in the proposed multiple payer plan that affect employers, such as the requirements that they make coverage available to their workers, it is likely that the state will need to obtain a Congressional waiver of the requirements of the federal ERISA statute. Any changes to be made to other federally funded programs, such as the Indian Health Service or Medicaid, would also require federal approval.

FINANCING

As indicated earlier, the establishment of either plan alternative will require additional state funds to support its activities. Among the possible sources of additional state revenues are the following:

- payroll taxes on employers and/or employees;
- a sales tax;
- "sin" taxes levied on alcohol or tobacco;
- income taxes;
- taxes on insurance premiums (multi-payer model only);
- taxes assessed on health care providers;
- transfers from other public programs; and
- gasoline taxes.

It should be noted that one financing option that the Authority discussed but about which it did not reach any conclusion was the possibility of establishing some form of "pay-or-play" requirement. This would provide the disincentive for businesses to drop health care coverage for their workers by establishing a new payroll tax from which employers providing coverage for their workers would be exempt.

The above list is illustrative only. In the upcoming months all possible mechanisms for raising the additional revenues needed to finance the universal access plans will be examined. In its October 1994 report to the Legislature, the Authority will identify preferred financing approaches, which may involve multiple revenue sources.

COST CONTAINMENT

In addition to its emphasis on expanding health care and improving access, S.B. 285 also calls upon the Authority to include in both of the universal access plans a series of features designed to control the growth in health care spending within Montana. The statute requires that each plan include provisions for the establishment of:

- a global budget for all health care spending; and

- a binding cap on overall health care expenditures.

By 1999, according to the statute, the average annual percent increase in statewide health care costs should not exceed the average annual percent increase for the nation's gross domestic product over the preceding five years.

To achieve the cost containment goals set by S.B. 285, the Authority has sought to incorporate in its alternative universal access plans a combination of cost containment features that reflect an effective balance of market-oriented and regulatory mechanisms, as well as efforts to improve the public's health-related behavior and its use of the health care system. For example, the decision to allow multiple health plans to compete on a quality and cost basis for patients under the proposed single payer system represents an attempt to introduce the benefits of market competition into an otherwise regulatory model.

The combination of market forces, improved consumer awareness, and provider cooperation could meet the statute's cost containment objectives by improving the efficiency of the health care delivery system, reducing the extent to which medically unnecessary procedures are performed, and eliminating unnecessarily duplicative health care resources.

However, should the above measures not be sufficient to achieve the cost containment objectives, then additional steps may need to be taken, including the establishment of caps on insurance premium increases or other more regulatory measures.

Finally, it should be noted that to monitor the extent to which the state's health care financing and delivery system achieves its cost containment objectives will require the development of a sophisticated health care data base that does not exist within the state today.

The Authority intends to explore these and other cost containment-related issues and options in considerable detail in the coming months.

STRENGTHENING THE HEALTH CARE DELIVERY SYSTEM

The Authority recognizes that to truly achieve the goal of providing all Montanans with access to needed care, efforts directed at providing universal coverage and controlling costs must be coupled with strategies to strengthen the infrastructure of the state's current health care delivery system and to address the resource shortages and maldistributions that exist within the state. To this end, the following positive developments should be encouraged within the state's delivery system:

- Increased administrative efficiencies;
- Appropriate collaboration/ consolidation among providers in a given geographic area within the state;
- Increased linkages among rural providers, as well as between rural providers and specialty care systems;
- Integration of the current system with other separate delivery systems (e.g., the Veterans Administration system), where appropriate;
- Expansion of managed care activities within the state, as long as standards are established to ensure that such managed care systems provide quality care and do not

inappropriately constrain individuals' access to needed services or providers' ability to deliver such services;

- Promotion of competition among health plans in areas of the state where this is feasible;

- Reorientation, conversion, or possibly even the closure of underutilized facilities, as long as such changes are made with local and regional input and are made in the context of a coordinated health resources management plan that identifies the implications of such changes on the long-run objectives of the system; and

- Expanded and more efficient use of mid-level practitioners, as long as such efforts are undertaken in the context of a broader plan that coordinates development of all levels of health care providers.

As part of the overall administrative and planning infrastructure authorized by S.B. 285, five regional health care planning boards have been established and given the responsibility for the development of regional health care resource management plans that will help guide the appropriate allocation of health care resources within each region. These regional plans will be aggregated into a statewide health care resources management plan which in turn will assist in understanding health care needs and targeting additional resources throughout the state. A draft of the statewide resource management plan will be prepared by late summer 1994.

GETTING FROM HERE TO THERE

The Authority has put forth these draft universal access plans to meet the mandate given to it by the Legislature and to provide citizens of Montana with a better sense of what options exist for reforming the current system. The proposals put forth in this preliminary report are ambitious, reflecting the significant charge given to the Authority in S.B. 285. However, consistent with the provision in S.B. 285 calling for the phased-in implementation of these plans and the fact that federal approval will be needed to carry out many aspects of these plans, the Authority will continue to work not only to refine the design of these universal access plans but also to develop a transition strategy for moving from the current system to either plan.

As the Authority carries on its deliberations of these important issues, it also will continue to encourage the involvement of all Montanans in the process.

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